Pathway to achieving the Triple Aim.

DSRIP Journey through the good, the bad and the ugly.

RWJ Robert Wood Johnson University Hospital

* Our Hospital
* Our Team
* Our Processes

* The Good

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Our Hospital

- Robert Wood Johnson University Hospital is a 965-bed hospital with campuses in New Brunswick and Somerville
- Robert Wood Johnson Health System is New Jersey's premier health system of choice.
- Has more than 10,100 employees, 3,250 medical staff members and 1,733 beds.
- Currently has $1.5 billion dollars in revenue,

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Our Team

* Project Champion
* Project Leader
* PI coordinator
* Administrative Assistant
* Social Worker
* Pharmacist
* Dietician
* Palliative Care
* Clinical integration
* Reimbursement
* IT team
* Finance team
* PI team

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*Steering Committee

Members:

1. Project Director: - Andrew Thomas
2. Director Clinical Integrations: - Lois Dornan
3. Director Reimbursement: - Tina Ford
4. PI Coordinator: - Augusta Agalaba
5. Administrative Assistant: - Lilian Folks
6. Social Worker: - Arianna Illa
7. Pharmacist: - Laurie Eckert

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Our Process

- Patient Identification
- Patient Screening
- Patient Encounter
- Home Visit
- Clinic Visit
- Follow up Phone Calls

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*Patient Identification

- IT Program identifies and generates a list of all low income patients that hits the ED in the previous 24 hours.
- List is sorted by Name, MRN, Age, Admit date, Diagnosis, Days since last discharge and payer.
- List is sent as an email alert to the DSRIP team at 7:05 AM daily.

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*Patient Screening

*APN reviews each patient chart to identify patients to be enrolled in the program.

1. Pregnant patients are excluded
2. CHF or AMI
3. History DM and/or HTN
4. History of COPD or Pneumonia
5. Patients with LACE Score > 11
6. Patients with < 30 days since last discharged

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Patient Encounter

- APN visits each enrolled patient at the bedside to introduce the program, assess social needs and schedule follow up appointment at the Discharge Clinic.
- Social Worker, Dietician, Pharmacist and Palliative care team are consulted as needed.
- “Soft medical management” to ensure patient is discharged on the most appropriate medications.

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*Home visits

* AMI and Heart Failure patients are seen at home within 24-48 hours of discharge by an APN.
* Patients without AMI/HF who are discharged to tertiary care facilities, are seen at that facility within 7 days by an APN.
* Patients without AMI/HF who cannot afford transportation to the Discharge Clinic are seen by an APN in the home within 7 days.
* Medication reconciliation
* Symptom check
* Patient teaching on diagnosis, red flags and expectations.
* Scales are provided to HF patients who do not have one.

* Medication reconciliation
* Reinforce education on disease processes and Red Flags.
* Assist with insurance or payer applications.
* Schedule and establish primary care follow up.
* Pharmacy and Social needs are addressed on site.
* Pertinent DSRIP data collected.

* Clinic Visits

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Second Clinic Visit

- Follow up visits scheduled for:
  - BP monitoring
  - INR monitoring
  - Lab reviews

Follow up Phone Calls

- Every patient receives three weekly follow up phone calls, starting the week after clinic visit.
  - Status update

*The Bad

- *Language Barrier
- *Medication Affordability
- *Homelessness
- *Partnerships

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* Milestones and Timelines
* Unintentional Paradox
* The Money
* Attribution list
* Attribution list
* Attribution list

* The Ugly

*Future State

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*Questions

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